

APPENDIX F-1**TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION
FORM DPA 1443 (HFS 1443), PROVIDER INVOICE**

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Use original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the form.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, which is the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of podiatric services.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

- | | | |
|-------------------------------|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 1. | Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet. |
| Required | 2. | Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet. |
| Required | 3. | Payee - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |
| Required | 4. | Role - Enter one of the following codes to define the relationship to the patient:
A - Attending podiatrist
B - Surgeon |
| Not Required | 5. | Emer - Leave blank. |
| Conditionally Required | 6. | Prior Approval - Enter the unique number from the computer generated prior approval notification, when billing for an item or service which approval has been obtained. |
| Optional | 7. | Provider Street - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If the address is not entered, the Department will not attempt corrections. |

Conditionally Required	8. Facility & City Where Service Rendered - This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office).
Optional	9. Provider City State ZIP - Enter city, state and ZIP code of provider.
Not Required	10. Referring Practitioner Name - Leave blank.
Required	11. Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
Required	12. Recipient No. - Enter the nine-digit number assigned to the individual as shown on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use no punctuation or spaces. Do not use the Case Identification Number.
Optional	13. Birthdate - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use the MMDDYYYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to recipient name or number errors. If the birthdate is not entered, the Department will not attempt corrections.
Not Required	14. H. Kids - Leave blank.
Not Required	15. Fam Plan - Leave blank.
Not Required	16. ST/AB - Leave blank.
Required	17. Primary Diagnosis Description - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Required	18. Primary Diag. Code - Enter the specific ICD 9-CM code without the decimal for the primary diagnosis described in Item 17.
Required	19. Taxonomy - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.

Optional	20.	Provider Reference - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. - Leave blank.
Not Required	22.	Secondary Diag Code - Leave blank.
	23.	Service Sections: Complete one Service Section for each item or service provided to the patient.
Required		Procedure Description/Drug Name, Form, and Strength or Size - Enter the description of the service provided or item dispensed.
Required		Proc. Code/NDC - Enter the appropriate CPT, HCPCS or NDC.
Conditionally Required		Modifiers - Enter the appropriate two-byte modifier(s) for the service performed. The Department can accept a maximum of 4 two-byte modifiers per Service Section.
Required		Date of Service - Enter the date the service was provided. Use MMDDYY format.
Required		Cat. Serv. - Enter the appropriate two-digit category of service code. 04 - Podiatric Services
Conditionally Required		Delete - When an error has been made that cannot be corrected enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required		Place of Serv. - Enter the two-digit Place of Service code from the following list: 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility

**Conditionally
Required**

Units/Quantity - Enter the approved quantity from the computer generated prior approval notification.

Not Required

Modifying Units - Leave blank.

**Conditionally
Required**

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the Chapter 100, General Appendix 9. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.

Spenddown – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples

When the date of service is the same as the "Spenddown Met" date on the DPA 2432 (Split Billing Transmittal) attach the DPA 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432 shows a recipient liability greater than \$0.00 the Service Section should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	The actual recipient liability as shown on DPA Form 2432.
TPL Date	The issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432 shows a recipient liability of \$0.00 the Service Section should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	The issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

**Conditionally
Required**

Status - If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown - TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered - TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered - TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met - TPL status code 04 is to be entered when the patient's Form DPA 2432 shows \$0.00 liability.

05 - Patient not covered - TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered - TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending - TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met - TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount - Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.

**Conditionally
Required**

TPL Date - A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Status**Code Date to be entered**

01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432, Split Billing Transmittal
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required 24. Optical Materials Only - Leave blank.

Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If an additional third party resource was identified for one or more of the services billed in service sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

**Conditionally
Required**

25. Sect. # - If more than one third party made a payment for a particular service, enter the service section number (1 through 6) in which that service is reported.

If a third party made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all Service Sections on the Provider Invoice.

**Conditionally
Required**

25A. TPL Code - Enter the appropriate TPL Code referencing the source of payment (Chapter 100, General Appendix 9). If the TPL Codes are not appropriate enter 999 and enter the name of the payment source in section 35.

**Conditionally
Required**

25B. Status - Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.

Conditionally Required	25C. TPL Amount - Enter the amount of payment received from the third party resource.
Conditionally Required	25D. TPL Date - Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above for correct coding of this field.)
Conditionally Required	26. Sect. # - (See 25 above).
Conditionally Required	26A. TPL Code - (See 25A above).
Conditionally Required	26B. Status - (See 25B above).
Conditionally Required	26C. TPL Amount - (See 25C above).
Conditionally Required	26D. TPL Date - (See 25D above).
Conditionally Required	27. Sect. # - (See 25 above).
Conditionally Required	27A. TPL Code - (See 25A above).
Conditionally Required	27B. Status - (See 25B above).
Conditionally Required	27C. TPL Amount - (See 25C above).
Conditionally Required	27D. TPL Date - (See 25D above).

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	28. Tot Charge - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
----------	-------------------------------------------------------------------------------------------------------------------------

- | | |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 29. Tot Deductions - Enter the sum of all payments submitted in the TPL Amount field in Service Sections 1 through 6. If no payment was received, enter zeroes (0 00). |
| Required | 30. Net Charge - Enter the difference between Total Charge and Total Deductions. |
| Required | 31. # Sects - Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections which were deleted because of errors. |
| Not Required | 32. Original DCN - Leave blank. |
| Not Required | 33. Sect. - Leave blank. |
| Not Required | 34. Bill type - Leave blank. |
| Conditionally Required | 35. Uncoded TPL Name - Enter the name of the third party resource. The name must be entered if TPL code 999 is used. |
| Required | 36-37 Provider Certification, Signature and Date - After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format. |

MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
 P.O. Box 19105
 Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or DPA 2432, Split Billing Transmittal) are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, NIPS Special Invoice Handling Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
 P.O. Box 19118
 Springfield, Illinois 62794-9118

Forms Requisition

Billing forms may be requested on our Web site at <http://www.hfs.illinois.gov/forms/> or by submitting a 1517 or 1517A as explained in Chapter 100, General Appendix 10.



PROVIDER INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID
USE CAPITAL LETTERS ONLY

PRV

IDPA USE ONLY

1. PROVIDER NAME (FIRST, LAST)			2. PROVIDER NUMBER		3. PAYEE	4. ROLE	5. EMER	6. PRIOR APPROVAL	
<input type="text"/>			<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
7. PROVIDER STREET			8. FACILITY & CITY WHERE SERVICE RENDERED						
<input type="text"/>			<input type="text"/>						
9. PROVIDER CITY		STATE	ZIP	10. REFERRING PRACTITIONER NAME (FIRST, LAST)					
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>					
11. RECIPIENT NAME (FIRST, MI, LAST)			12. RECIPIENT NUMBER		13. BIRTHDATE		14. H. KIDS	15. FAM. PLAN	16. ST/AB
<input type="text"/>			<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
17. PRIMARY DIAGNOSIS DESCRIPTION									18. PRIMARY DIAG. CODE
<input type="text"/>									<input type="text"/>
19. TAXONOMY		20. PROVIDER REFERENCE			21. REF. PRAC. NO.		22. SECONDARY DIAG. CODE		
<input type="text"/>		<input type="text"/>			<input type="text"/>		<input type="text"/>		

23. SERVICE SECTIONS

1	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
2	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
3	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
4	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
5	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		
6	PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE				PROC. CODE/NDC		MODIFIERS		DATE OF SERVICE		CAT. SERV.	DELETE
	<input type="text"/>				<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	P.O.S.	UNITS / QUANTITY	MODIFYING UNITS	TPL CODE	STATUS	TPL AMOUNT		TPL DATE		PROVIDER CHARGE		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		

24. OPTICAL MATERIALS ONLY												
24A. RX TYPE		24B. LENS TYPE		24C. CORRECTION CHANGE		25. SECT. #	25A. TPL CODE	25B. STATUS	25C. TPL AMOUNT		25D. TPL DATE	28. TOT. CHARGE
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
24D. RIGHT SPHERE		24E. RIGHT CYLINDER		24F. RIGHT PRISM		26. SECT. #	26A. TPL CODE	26B. STATUS	26C. TPL AMOUNT		26D. TPL DATE	29. TOT. DEDUCTIONS
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
24G. LEFT SPHERE		24H. LEFT CYLINDER		24I. LEFT PRISM		27. SECT. #	27A. TPL CODE	27B. STATUS	27C. TPL AMOUNT		27D. TPL DATE	30. NET CHARGES
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>

31. #SECT	32. ORIGINAL DCN	33. SECT	34. BILL TYPE	35. UNCODED TPL NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE SIDE AND IS PART OF THIS BILL.

<input type="text"/>	<input type="text"/>
36. PROVIDER SIGNATURE (DO NOT USE RUBBER STAMP)	37. DATE

APPENDIX F-1b

PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Carrier or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare Carrier on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare Carrier automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare Carrier but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,

- the provider's Provider Number in the lower right corner of Field 33, and
- the one digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name.

If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare Carrier. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.

APPENDIX F-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 1409, PRIOR APPROVAL REQUEST

Form DPA 1409, Prior Approval Request, is to be submitted by the podiatrist for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Form DPA 1409 is a multi-part form. Appendix F-2a contains an example of the form.

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable; leave blank.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

		Document Control Number - leave blank.
Not Required	1.	Trans Code (Transaction Code) - Leave blank.
Not Required	2.	Prior Approval Number - Leave blank.
Required	3.	Case Name - Enter the case name from the participant's MediPlan Card, Temporary MediPlan Card or KidCare Card. The case name appears on the front of the card in conjunction with the mailing address.

- Required** 4. **Recipient Name** - Enter the name of the participant for whom the service or item is requested.
- Required** 5. **Recipient Number** - Enter the nine digit recipient number assigned to the participant for whom the service or item is requested. This number is found to the right of the participant's name on the back of the MediPlan or KidCare Card.
- Required** 6. **Birth date** - Enter the participant's birth date. This is a six-digit field. Entry must be in six digit MMDDYY format. (January 28, 2001 is entered as 012801.)
- Conditionally Required** 7. **Inst Set (Institutional Setting)** - An entry in this field is required only when the participant resides in a long term care facility.

Enter one of the following codes to identify the arrangement:

H = Long-Term Care Facility

I = Sheltered Care Facility

- Required** 8. **Case Identification Number** - Enter the Case Identification Number from the participant's MediPlan Card, Temporary MediPlan Card or KidCare Card. This number is found on the primary portion (front) of the card immediately above the case name and mailing address.
- Required** 9. **Recipient Street Address** - Enter the participant's current street address. The Department will use this information to mail the participant the "Notice of Decision on Request for Medical Service/Item".
- Conditionally Required** 10. **Facility Name** - An entry in this field is required only when an entry appears in Item 7 above.
- Required** 11. **Recipient City** - Refer to Item 9 above.
- Conditionally Required** 12. **Facility City** - An entry in this field is required only when an entry appears in Items 7 and 10.
- Required** 13. **Requesting Provider Name** - Enter the name of the requesting provider.

- | | |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 14. Requesting Prov No - Enter the requesting provider's Provider Number exactly as shown on the Provider Information Sheet. |
| Required | 15. Provider Street - Enter the provider's address. This information will be used to return a copy of the processed (approved/denied) request. |
| Required | 16. Provider Telephone - Enter the telephone number of the provider's office. This information is helpful in instances when the Department needs additional information in order to act upon the request. |
| Required | 17. Provider City, State, Zip - Enter the provider's city, state and zip. |
| Not Required | 18 - 26 Leave blank. |
| | 27. Service Sections - The form provides space to request a maximum of three services/items. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow: |
| Required | Req. Proc. Code (Requested Procedure Code) - Enter the five-digit procedure code which identifies the procedure for which approval is requested. |
| Required | Req Qty (Requested Quantity) - Enter the number of items or the number of times the service is to be performed. |
| Required | Prov Charge (Provider Charge) - Enter the provider's charge for the service(s). |
| Required | Cat. Serv. (Category of Service) - Enter the appropriate Category of Service code.
04 - Podiatric Services |
| Required | Description - Briefly describe the services, items or materials to be provided. If additional space is needed, provide the information on letterhead paper, identifying the patient by name and Recipient Identification Number. |
| Required | 28. Medical Necessity - The provider is to enter a statement as to the need for the service(s) requested. In addition to a narrative explanation, a diagnosis should be provided. If additional space is |

needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.

Required **29. Supplying Provider Signature** - The form is to be signed in ink by the individual who is to provide the service.

Required **31. Request Date** - Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top, signed copy of the request is to be mailed to:


Illinois Department of Public Aid
Bureau of Comprehensive Health Services
Post Office Box 19105
Springfield, Illinois 62794-9105

The remaining copies may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be provided until the approval notification is received.

APPENDIX F-2a

Reduced Facsimile of Form DPA 1409, Prior Approval Request

	PRIOR APPROVAL REQUEST ILLINOIS DEPARTMENT OF PUBLIC AID	Document Control Number <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
		CCC
*Completion Mandatory, Ill.Rev.Stat., PA Code, penalty non-payment. Form Approved		
1. Trans Code <div style="border: 1px solid black; width: 40px; height: 20px;"></div>	2. Prior Approval Number <div style="border: 1px solid black; width: 140px; height: 20px;"></div>	3. Case Name <div style="border: 1px solid black; width: 200px; height: 20px;"></div>
4. Recipient Name (First, MI, Last) <div style="border: 1px solid black; width: 180px; height: 20px;"></div>	5. Recipient Number <div style="border: 1px solid black; width: 120px; height: 20px;"></div>	6. Birth date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>
		7. Inst. Set <div style="border: 1px solid black; width: 40px; height: 20px;"></div>
		8. Case Number <div style="border: 1px solid black; width: 80px; height: 20px;"></div>
9. Recipient Street <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	10. Facility Name <div style="border: 1px solid black; width: 260px; height: 20px;"></div>	
11. Recipient City <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	12. Facility City <div style="border: 1px solid black; width: 180px; height: 20px;"></div>	
13. Requesting Provider Name <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	14. Requesting Prov. No. <div style="border: 1px solid black; width: 120px; height: 20px;"></div>	
15. Provider Street <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	16. Provider Telephone <div style="border: 1px solid black; width: 120px; height: 20px;"></div>	
17. Provider City <div style="border: 1px solid black; width: 280px; height: 20px;"></div>		
18. Supplying Provider Name <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	19. Supply Prov. No. <div style="border: 1px solid black; width: 120px; height: 20px;"></div>	
20. Provider Street <div style="border: 1px solid black; width: 280px; height: 20px;"></div>	21. Provider Telephone <div style="border: 1px solid black; width: 120px; height: 20px;"></div>	
22. Provider City <div style="border: 1px solid black; width: 280px; height: 20px;"></div>		
23. Aprv. Authority <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	24. Disp. Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	25. Approving Authority Signature <div style="border: 1px solid black; width: 450px; height: 30px;"></div>
		26. Receipt Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>
27. SERVICE SECTIONS		
1 DISP STATUS <input type="checkbox"/> 0=Denied <input type="checkbox"/> 1=Aprv.	Req.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Total Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Req.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Begin Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>
	Prov.Charge <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Unit Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div> End Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Cat.Serv <div style="border: 1px solid black; width: 40px; height: 20px;"></div>
	Description <div style="border: 1px solid black; width: 340px; height: 40px;"></div> Reason For Denial <div style="border: 1px solid black; width: 340px; height: 40px;"></div>	
2 DISP STATUS <input type="checkbox"/> 0=Denied <input type="checkbox"/> 1=Aprv.	Req.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Total Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Req.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Begin Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>
	Prov.Charge <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Unit Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div> End Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Cat.Serv <div style="border: 1px solid black; width: 40px; height: 20px;"></div>
	Description <div style="border: 1px solid black; width: 340px; height: 40px;"></div> Reason For Denial <div style="border: 1px solid black; width: 340px; height: 40px;"></div>	
3 DISP STATUS <input type="checkbox"/> 0=Denied <input type="checkbox"/> 1=Aprv.	Req.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Proc.Code <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Total Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Req.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Aprv.Qty. <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Begin Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>
	Prov.Charge <div style="border: 1px solid black; width: 60px; height: 20px;"></div> Unit Amount <div style="border: 1px solid black; width: 60px; height: 20px;"></div> End Date <div style="border: 1px solid black; width: 60px; height: 20px;"></div>	Cat.Serv <div style="border: 1px solid black; width: 40px; height: 20px;"></div>
	Description <div style="border: 1px solid black; width: 340px; height: 40px;"></div> Reason For Denial <div style="border: 1px solid black; width: 340px; height: 40px;"></div>	
28. Medical Necessity <div style="border: 1px solid black; width: 260px; height: 40px;"></div>		
This is to certify that the information above is true, accurate and complete.		
29. Supplying Provider Signature <div style="border: 1px solid black; width: 350px; height: 20px;"></div>		30. Request Date <div style="border: 1px solid black; width: 80px; height: 20px;"></div>
DPA 1409 (R-1-92) IL478-1100		

APPENDIX F-3
Reduced Facsimile of Request for Approval for Podiatry Services



Illinois Department of Public Aid

REQUEST FOR APPROVAL FOR PODIATRY SERVICES

Patient Name _____ Recipient Number _____

Address (Street) _____ (City) _____

1. Diagnosis: _____

2. Past Treatment Provided For Presenting Condition: _____

3. Past Surgery (Include Type and Date): _____

4. Orthomechanical Device (Include Procedure code and Date): _____

5. Description of Item or Service for Which Approval is Being Requested: _____

6. Medical Necessity/Prognosis: _____

Completion mandatory, Ill. Rev. Stat., Ch.23, P.A. Code, penalty non-payment. Form approved by Forms Management Center.

Provider Name _____ Date _____

DPA 314A (R-5-2000)


IL478-1060




APPENDIX F-4

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic F-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix F-4a. The item or area numbers that correspond to the explanations below appear in small circles  on the sample form.

FIELD	EXPLANATION
 PROVIDER KEY	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
 PROVIDER NAME AND LOCATION	This area contains the NAME AND ADDRESS of the provider as carried in the Department's records. The three-digit COUNTY code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The TELEPHONE NUMBER is the primary telephone number of the provider's primary office.
 ENROLLMENT SPECIFICS	<p>This area contains basic information reflecting the manner in which the provider is enrolled with the Department.</p> <p>PROVIDER TYPE is a three-digit code and corresponding narrative which indicates the provider's classification.</p>

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

- 01 = Individual Practice
- 02 = Partnership
- 03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

- B = Active
- I = Inactive
- N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in the Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

- A = Exception Requested By Audits
- C = Citation to Discover Assets
- G = Garnishment
- S = Exception Requested By Provider Participation Unit
- T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** is the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

- 4 **CERTIFICATION/
LICENSE NUMBER** This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.
- 5 **S.S.#** This is the provider's social security or FEIN number.
- 6 **SPECIALTY AND
CATEGORIES
OF SERVICE** This area identifies special licensure information and the types of services a provider is enrolled to provide.
- SPECIALTY CODE** is not applicable to podiatrists.
- ELIGIBILITY CATEGORY OF SERVICE** contains a three-digit code and corresponding narrative indicating the type of service a provider is authorized to render to patients covered under the Department's Medical Programs. The proper code is:
004 = Podiatric Services
- This entry is followed by the date that the provider was approved to render podiatric services.
- 7 **PAYEE
INFORMATION** This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 SIGNATURE

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX F-4a Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

PROVIDER INFORMATION SHEET

RUN DATE: 06/02/02
RUN TIME: 11:47:06
MAINT DATE: 06/02/02
PAGE: 84

1 --PROVIDER KEY--
016012345

2 PROVIDER NAME AND ADDRESS
GOODNIGHT E.J.
1421 MY STREET
ANYTOWN, IL 62000

3 PROVIDER TYPE: 013 - Podiatrist
ORGANIZATION TYPE: 01 - Individual Pract
ENROLLMENT STATUS B - ACTIV NOCST BEGIN 01/15/02 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER: (217) 742-1234
D.E.A. #:
RE-ENROLLMENT INDICATOR: N DATE: 11/15/86

CERTIFIC/LICENSE NUM - 016012345 ENDING 03/31/02
LAST TRANSACTION ADD AS OF 05/21/02

4

5 AGR: YES BILL:NONE
UPIN #:
S.S. #:331313131
CLIA #:

6 HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /
ELIG

COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	ELIG	TERMINATION REASON
004	Podiatry Services	06/15/02					

7 PAYEE

CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	E. J. Goodnight DBA: MEDICARE/PIN: 355730/L12345	1421 MY STREET	ANYTOWN	IL	62000	016012345-62000-01 VENDOR ID: 01		11/15/86
2	FOOTCARE SPECIALISTS DBA: MEDICARE/PIN: 777444/L54321	1010 ADAMS STREET	ANYTOWN	IL	62000	446655444-62000-02 VENDOR ID: 02		10/12/96

8

***** PLEASE NOTE: *****
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____